THE JAMAICA HOSPITAL MEDICAL CENTER
DEPARTMENT OF PSYCHIATRY MANUAL

SUBJECT: USE OF RESTRAINTS FOR PRIMARY BEHAVIORAL HEALTH NEEDS

ISSUED: 4/95

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I. PHILOSOPHY

Restraint can be defined as any physical method of restricting a person's freedom of movement, physical activity, or normal access to his or her body. Jamaica Hospital Medical Center recognizes that all patients have the right to considerate, respectful care at all times and under all circumstances, with recognition of their personal dignity, privacy and safety, in the least restrictive environment. Restraints will only be used for the safety of patients or others when all other interventions have been exhausted. Patient's safety needs will be individually evaluated and the least restrictive, effective type of intervention/restraint utilized.

II. POLICY

There are times in which a patient's behavior may necessitate the use of restraints. Physical restraints shall be used to prevent a patient from injuring self or others, and **only as a last resort** when all other available psychological or physical modalities are ineffective. Restraints may not be employed as punishment, for the convenience of staff, or as a substitute for treatment programs. When a patient requests restraints that are considered therapeutic, the restraints procedures shall be implemented according to the guidelines outlined in this policy.A risk assessment must be made in regard to a patient's medical condition(e.g. cardiac, respiratory) and abuse issues prior to placement in restraints. All patients requiring restraints must be restrained in the least restrictive fashion and for the least amount of time appropriate to their medical condition and their mental status. The restraint must be ordered in writing by a physician after a face to face

evaluation or in an emergency initiated by a registered nurse. If initiated by a registered nurse the physician must be consulted as soon as possible and the restraint order must be written by a physician within 30 minutes after a face to face evaluation of the patient.

EXCEPTIONS:

A. These guidelines do not cover those devices customarily used in conjunction with medical, diagnostic, surgical procedures/treatments or movement/transfer of patients when such cases are considered a regular or usual part of treatment, e.g., body restraint (during surgery). Nor do they include safety restraints for children in cribs, high chairs or strollers or the use of medically indicated devices that are intended to stabilize a body part, e.g., back brace or splint. They do not include commonly used devices which allow all extremities uninhibited movement, such as bed rails, tabletop chairs, wheelchair trays or gerichairs.

B. This policy does not apply to forensic and correction restrictions used for security purposes.

IV. PURPOSE

To establish guidelines for the safe, effective use of restraints in accordance with state and federal regulations. This policy is applicable to all patients presenting in the outpatient/inpatient programs and applies to these interventions that are used involuntarily as indicated by individual orders. Specifically, it is to maintain patient's safety and protect from injury to self and others.

V. RESPONSIBILITY

1) It is the responsibility of the physician/psychiatrist to assess and determine the clinical situation for the use of restraints.

2) Using the preprinted physician/psychiatrist order form for "**PRIMARY BEHAVIORAL HEALTH NEEDS** " the physician orders the type of restraints to be used, specifies the length of time the order is effective and checks off the reason for the restraints (see attached form).

3) The physician must review the patient's chart paying special attention to the plan of care and medication.

4) The registered nurse can place a patient in restraints in an emergency situation if the activity the patient is engaging in presents an immediate danger to self and others. The physician must be summoned immediately and the supervising nurse notified. It is the responsibility of the notified physician to document in the clinical record, the reason/s for not responding within the thirty minutes time period.

5) Under the direction of the registered nurse, nursing staff apply and remove restraints, provide constant observation, assessments and nursing care.

VI. PROCEDURE

1) A patient should only be placed in restraints if their behavior presents a danger to self or others. Use of restraints is based on the patient's needs in the immediate care environment and the interaction of the patient and the staff with other patients in that environment and not solely on prior history of use or history of dangerous behavior. Less restrictive interventions must be considered before the ordering of restraints. **Less restrictive interventions includes but are not limited to physiologic assessment, verbal intervention, quiet room, companionship, constant observation, medication offered, environmental change etc.**

2) All contrabands must be removed from patients before placing them in restraints.

3) Written orders for restraint of patients with primary behavioral health needs are time limited to:

- ☐ **4 hours for adults**
- ☐ **2 hours for children and adolescents ages 9-17**
- ☐ **1 hour for patients under age 9**

4) If the patient still need restraints after the initial episode then the patient must be re-evaluated by a physician and a new order written and restraint policy and procedure followed.

5) If an emergency situation exists in which the patient is engaging in an activity that presents an immediate danger to self or others and a physician is not immediately available, restraints may be initiated under the direct supervision of a registered nurse. The physician must respond within thirty minutes to assess the patient and write the

order for restraints. **In no event shall restraint be applied for longer than one hour without the written order of a physician.**

6) A patient may only be placed in restraint under the supervision of a registered nurse.

7) Nursing staff are authorized to apply and remove restraints.

8) Security officers may be called to assist in holding an agitated/combative dangerous patient while nursing staff apply restraints.

9) The following assessments must be made and documented on the Restraint/Seclusion Progress Record every 15 minutes by Nursing Staff.

- ☐ Circulation check/skin condition of the restrained limbs taking note of color, sensation, temperature changes and tightness.
- ♦ Changes in mental status, level of anxiety and agitation, psychomotor activities, verbal, and nonverbal behavior.
- ♦ Patient awake or asleep.

10) The following physical care must be provided as needed or at least every hour by the Nursing Staff in addition to the above.

- ♦ Adjust restraint application;
- ♦ Allow patient to feed self; if appropriate. **Raise head part of the bed and feed patient in an upright position only.**
- ♦ Additional fluids between meals;
- ♦ Offer snacks;
- ♦ Mouth care;
- ♦ Toileting

11) Complete vital signs including BP must be taken and assessed at the initiation
of restraints if possible, every hour afterwards, and the end of the restraint period
or as indicated by the patient's condition and/or physician's order. Pulse and respiration must be taken every 15 minutes. If unable to take vital signs it must be so documented.

12) Restraints must be released, a limb at a time, every hour for 5-15 minutes except when the patient is asleep or still combative. When restraints are released, the areas restrained should be inspected, massaged (unless contraindicated) and skin lotion applied. Range of motion exercises should be provided and the patient is to be repositioned when possible. Toileting and nourishment should be offered at this time .

13) A patient in restraint shall be released from restraint every **two hours**, except if still agitated or when asleep.

14) All patients placed on restraints must be placed on **CONSTANT OBSERVATION** for the duration of restraints.

15) There must be a staff and patient debriefing after each application of restraints.

VII. DISCONTINUATION OF RESTRAINTS

1) A physician may order the discontinuation of restraints.

2) A registered nurse may release a patient from restraints prior to the order's expiration time if the patient's condition improves eg less agitated, able to contract for safety and control behavior. The physician must be contacted immediately.

3) If a patient is released from restraints prior to the expiration of an order and the patient threatens to hurt self or others, the patient may be re-restrained pursuant to a new physician's order.

VIII. DOCUMENTATION

1) The physician must order the restraint in writing on the preprinted order form for "Primary Behavioral Health Needs".

2) On the Restraint/Seclusion Progress Record, the registered nurse enters the date, starting and ending times, the unit's name, the type of restraint ordered, and the interventions attempted prior to implementing restraints. The

physician and registered nurse dates and times their brief evaluation notes.

3)The initial physician and nurse progress note must be dated, timed and the reason/indication for the application of restraints and the type of restraints used must be documented. The progress notes must also indicate that the procedure was explained to the patient/family when possible or that an attempt was made.

4) Nursing staff assessments/notes must be done every fifteen (15) minutes when the patient is placed in restraint. These must be recorded on the Restraints/Seclusion Progress Record.

5) Prior to each subsequent period of restraints, a progress note must be written to include a description of the patient's physical activity, verbal content, notation of nourishment and elimination needs, and provision for personal hygiene.

6) When restraints are discontinued, a progress note must indicate the date, time and description of the behavior and if any injuries were suffered by the patient.

IX. FAMILY AND PATIENT EDUCATION

Episodes of restraints must be considered in the treatment planning process and addressed by appropriate goals, objectives and actions as indicated. Families must be informed of episodes of restraint if patient consents and be so documented. Families and patients must be educated and involved in the treatment process when appropriate.

X. LOCATION OF RESTRAINED PATIENTS

Patients are to be restrained in an area where they can be observed by staff with respect for their dignity. Restrained patients must be kept in a safe environment where they are protected from other potentially violent or provocative patients or visitors.

XI. TYPES OF RESTRAINTS

1) Restraints must be approved commercial restraints or non-commercial

restraints made of unbleached muslin with quilted center portions or nylon with Velcro straps. Permitted forms of restraints are:

- Camisoles
- Wrist and ankle restraints (4 point) and 5 point- added soft restraint across the chest.
- Mittens

The above restraints are located in the nurses' station of each unit.

Plain bed sheets and locked restraints must never be used to restrain a patient.

2) It is never appropriate for clinical personnel to write an order for restraint by handcuffs. Handcuffed patients brought to the hospital by law enforcement officers must be quickly assessed to determine if the handcuffs can be safely and immediately removed.

XII. PERFORMANCE IMPROVEMENT

The use of restraints is part of the Performance Improvement process of the hospital. Concurrent reviews of patients placed in restraints and medical records of patients placed in restraints will be reviewed for the appropriateness of restraints, the adequacy of patient monitoring, and the completion of documentation. A log book of all episodes of restraints is maintained on each unit which includes the date, time, patients' name, reasons for restraints, type of restraint and the person who made the decision to place the patient in restraint. All data is analyzed/used to identify opportunities for improvement. Particular attention is paid to instances of multiple episodes of use for individual patients and the frequency of restraints used by each staff member. The clinical leadership of the department is notified of any instance in which a patient remains in restraint for more then 12 hours, or experiences two or more separate episodes of restraint of any duration within 12 hours.

XIII. EDUCATION AND COMPETENCY

Competent staff are essential to using restraints safely and to protect the patient during use. Appropriate ongoing training for staff will be provided. Only those staff members trained in the specific use of restraints may apply them. Staff will apply restraints according to the manufacturer's directions. Competency in the application of restraints will be

EXHIBIT D